INDIANA STATE BUDGET AGENCY

Report to Budget Committee Concerning a Regional or Multi-State Prescription Drug Aggregate Purchasing Program

November 1, 2004

A MILLIMAN GLOBAL FIRM

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EXECUTIVE SUMMARY

House Enrolled Act (HEA) 1265 requires in Section 7 that the Budget Agency shall conduct a study and submit a written report to the Budget Committee that:

1) Sets forth the status of the participation of other Midwestern states; and

2) Researches the feasibility, costs, and legal parameters of Indiana's participation;

in a regional or multi-state prescription drug aggregate purchasing program.[1]

This report has been prepared pursuant to this requirement.

The primary findings included in this report include:

- There are three primary operating multi-state prescription drug aggregate purchasing programs available to Midwestern states: National Medicaid Pooling Initiative (NMBP); RX Issuing States (RxIS) project; and The Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP).[2]

- Some Midwestern states participate in more than one multi-state prescription drug aggregate purchasing program.

- Michigan currently participates in NMBP, which is a Medicaid aggregate purchasing pool.[3] Minnesota has filed State Plan Amendments with the Centers for Medicare and Medicaid Services (CMS) indicating they intend to participate in NMBP.[3]

- The state employees of Missouri, Ohio, and West Virginia currently participate in RxIS.[3]

- Various agencies from the states of Illinois, Indiana, Kentucky, Michigan, Minnesota, Missouri, and Wisconsin participate in MMCAP.[4]

- Indiana's participation in any or all three of these programs is feasible as each program may be individually accessed by state agencies and programs with flexible terms. There are, however, restrictions that limit some agencies and programs to certain multi-state prescription drug aggregate purchasing programs.

- The cost associated with participation in one of the current multi-state prescription drug aggregate purchasing programs is not currently determinable, however, can be readily estimated from a comparison of each program's financial terms to the terms that Indiana has negotiated as part of its aggregate purchasing program. The analysis conducted for Indiana's aggregate prescription purchasing program included an algorithm that can be used for such a comparison.[5]

- Participation in a multi-state prescription drug aggregate purchasing program will have certain federal regulatory restrictions limiting the potential participation options. The primary restrictions relate to the pooling of Medicaid populations with non-Medicaid populations. These restrictions can be addressed if Medicaid participates in an existing Medicaid only program while other state agencies and programs participate in non-Medicaid programs.[6]

- Each state is relatively unrestricted as to the design of its programs and how such designs may be implemented within a multi-state prescription drug aggregate purchasing program.[7]

- Participation by Indiana Medicaid will require approval of State Plan Amendments (SPA) by CMS. No new Indiana legislation is necessary to enable participation by non-Medicaid programs.

REPORT TO BUDGET COMMITTEE CONCERNING A REGIONAL OR MULTI-STATE PRESCRIPTION DRUG AGGREGATE PURCHASING PROGRAM

INTRODUCTION

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1) Sets forth the status of the participation of other Midwestern states; and

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NATIONAL STATUS OF MULTI-STATE PRESCRIPTION DRUG AGGREGATE PURCHASING PROGRAMS

Current Operational Pools

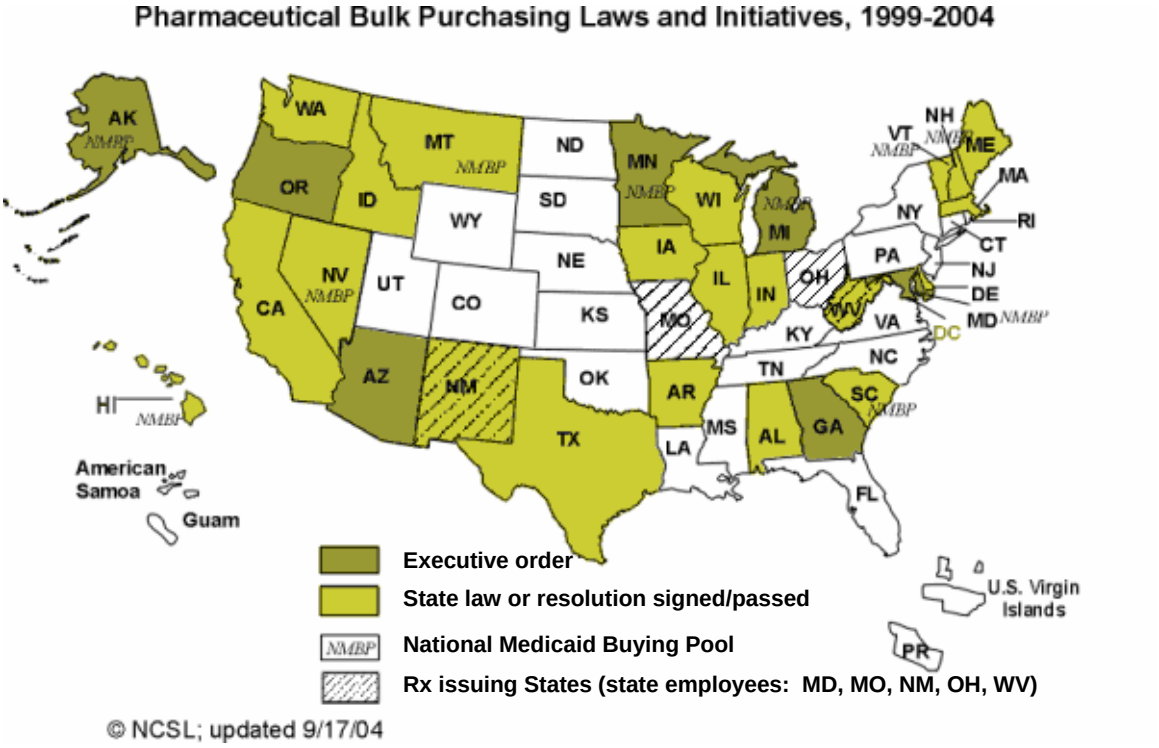
The National Conference of State Legislatures (NACSL) periodically provides a summary of prescription law initiatives being considered or promulgated by each of the state legislatures. The NACSL maintains a database specifically for bulk purchasing programs in which state activity is periodically updated. (Bulk purchasing or bulk buying pools are used interchangeably with *consolidated or aggregate purchasing* of pharmaceuticals.) The most recent edition of this database is dated September 14, 2004. As of this date, the NACSL reports three operating multi-state bulk buying pools as follows.[2]

1. **RxIS Project** (Rx Issuing States). This program now includes five states and is lead by an initiative developed by West Virginia. Delaware, Missouri, New Mexico, Ohio, and West Virginia participate in RxIS. RxIS, which covers public employees, includes an estimated 570,000 lives with annual spending of $400 million.[8]

2. **NMBP** (National Medicaid Buying Pool or National Medicaid Pooling Initiative). This program includes Nevada, New Hampshire, Vermont, Michigan, and Alaska. Hawaii, Minnesota, and Montana have also submitted State Plan Amendments (SPA) and received approval from CMS. These states will also join NMBP. NMBP includes an estimated 1.5 million lives with annual spending of $1.2 billion.[2]

3. **MMCAP** (The Minnesota Multistate Alliance for Pharmacy). Various agencies among 41 states participate in this program. Total estimated participation and annual spending values are not available for MMCAP.[4]

The following chart provides a summary of operating programs and state legislative initiatives as of September 2004.



Source: National Conference of State Legislators; Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans, 2004; September 14, 2004.

Appendix I contains an inventory of state activities reported as of September 2004.

All of these programs have either reported or have provided estimates of savings resulting from participation in the multi-state prescription drug aggregate purchasing programs. The following savings values are reported or estimated for the operating programs.

1. **RxIS Project.** West Virginia estimates that RxIS will save $25 million over 3 years representing an estimated 5% savings over the pharmacy program that RxIS replaced.[2]

2. **NMBP.** Alaska, Michigan, Nevada, New Hampshire, and Vermont estimate a total savings of $12.9 million in 2004 representing less than 1% of total estimated prescription drug spending.[2]

3. **MMCAP.** No aggregate savings estimates are available for MMCAP; however, the net discount to average wholesale cost (AWP) is estimated to be 23.7%.[2] This savings reflects both brand and generic prescriptions. Typical commercial pharmacy benefit manager (PBM) contracts yield an estimated 15% discount from AWP for brand drugs and an estimated 50% discount from AWP for generic drugs. The combined discount for commercial PBM contracts is estimated to be 23.0% from AWP.[9]

Basis for Program Savings

The aggregate purchasing approach to acquire prescription drugs has been developed by various states in order to provide them with (a) increased market leverage and the opportunity for deeper price discounts and manufacturer rebates; (b) a higher level of administrative efficiency, which may reduce the service costs associated with providing prescription benefits; (c) access to utilization management services; and (d) an opportunity to introduce systemic program changes that promote more favorable net unit prices.

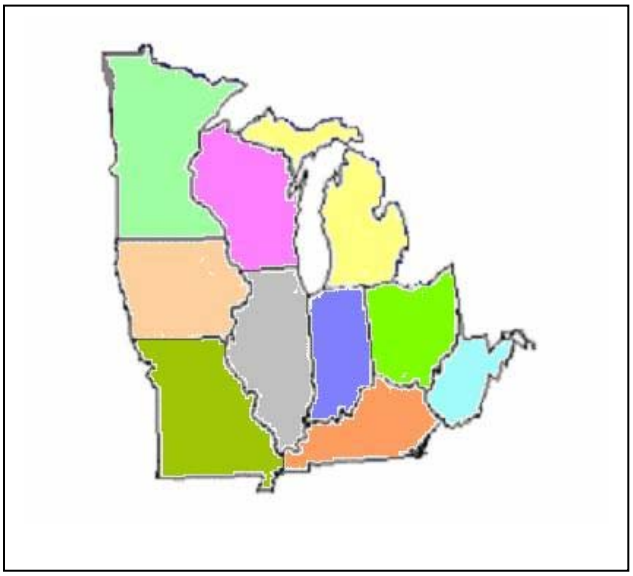
One of the more comprehensive analyses of aggregate purchasing plans was underwritten by the Heinz Family Philanthropies in 2001. The report analyzed the savings and source of savings for the aggregate purchasing plan established by Georgia for its Medicaid program. The Georgia program is a single-state purchasing program established under the name Georgia Consolidated Drug Purchasing Program. The reports identifies savings resulting from changes made by the program with respect to plan design, an expansion of the state's maximum allowable cost (MAC) list for generic drugs, a customized preferred drug list, more competitive financial contract terms for drug prices, and enhanced program oversight. The study notes that a portion of the overall savings was attributable to the negotiation of a more competitive financial arrangement with one plan administrator. The majority of the state's savings, however, were attributable to changes in plan design, implementation of an expanded MAC, and consistency within its preferred drug list and coordination with benefit design strategies to promote preferred drug use (three tier co-payment structures).

The report on the Georgia program concludes that the majority of the savings realized will be the direct result of program changes that could have been implemented absent an aggregate purchasing agreement. The report also credits the existence of the program for

allowing such changes to be made due to the increased market concentration and the ability to influence change for a critical mass of participants.

STATUS OF MULTI-STATE PRESCRIPTION DRUG AGGREGATE PURCHASING PROGRAM PARTICIPATION BY OTHER MIDWESTERN STATES

States Defined as Midwestern



A number of states contiguous and near Indiana were defined to compose Midwestern states. The chart summarizes the states that are the subject of this report: Illinois, Iowa, Kentucky, Michigan, Minnesota, Missouri, Ohio, and West Virginia. This section provides a summary of the states that participate in multi-state prescription drug aggregate purchasing programs as well as the interest these states have in participating in a multi-state prescription drug aggregate purchasing program.

Participation Status of Midwestern States

Some Midwestern states participate in more than one multi-state prescription drug aggregate purchasing program.

Michigan currently participates in NMBP, which is a Medicaid aggregate purchasing pool. Minnesota has filed State Plan Amendments with the Centers for Medicare and Medicaid Services (CMS) indicating they intend to participate in NMBP.[10]

The state employees of Missouri and West Virginia currently participate in RxIS.[10]

Various agencies from the states of Illinois, Indiana, Kentucky, Michigan, Minnesota, Missouri, and Wisconsin participate in MMCAP.[10]

Participation Interest by Midwestern States

A survey was submitted to the Midwestern states to assess the status of participation in a multi-state prescription drug purchasing program, the details for those states that participate in a program, as well as interest in participating in a multi-state prescription drug purchasing program. A survey questionnaire, contained in Appendix II, was developed to determine whether states were participating in multi-state programs, the types of beneficiaries included in the programs, general interest in joining such a program, and the details associated with their aggregate purchasing program.

Minnesota, West Virginia, and Wisconsin responded to the survey. Appendix III contains a chart that summarizes the responses from these states. The Indiana State Budget Agency will follow up with the non-responding states to collect the survey information.

All the responding states indicated an interest in participating in a multi-state prescription drug aggregate purchasing program, which is to be expected as each state currently participates in an aggregate pool of some kind.

West Virginia participates in a prescription aggregate purchasing program that is similar to the Indiana prospective program in that it includes the following state programs and accounts: CHiP population; state employees; state universities and colleges; and schools and local units of government.[10] These state programs and accounts participate in aggregate purchasing through the RxIS program. The CHiP program does not technically participate in the RxIS program, however, it uses the same PBM and administrative contracts (parallel terms) as the RxIS program.[10]

Minnesota participates or plans to participate in two aggregate purchasing programs: NMBP and MMCAP.[10] The state's Medicaid program plans to participate in NMBP. The state universities and colleges, schools and local units of government, and prisons and state hospitals all participate in the MMCAP.

Wisconsin has only one state program, prisons and state hospitals, participating in an aggregate purchasing program.[10] Wisconsin's prisons and state hospitals currently participate in MMCAP.

FEASIBILITY, COSTS, AND LEGAL PARAMETERS OF INDIANA'S PARTICIPATION

Feasibility

Three multi-state prescription drug aggregate purchasing programs are available for access by the state of Indiana: NMBP, RxIS, and MMCAP. The Indiana Department of Health and the Family Social Services Agency currently participate in MMCAP.

All existing multi-state prescription drug aggregate purchasing programs have specific guidelines and associated rules that govern participation. An exhaustive review of the guidelines and rules will be necessary prior to any participation by Indiana in order to ensure no conflicts with state law. No legislation is required for Indiana to participate in the RxIS since Medicaid is not part of the program. Participation by Medicaid will require the approval of an SPA by CMS.

Participation in any or all three of these programs is feasible, however, as each program may be accessed by state agencies and programs. A potential advantage to participating in the current programs is that these programs, in addition to being already established, have passed the regulatory scrutiny of state and federal oversight. State agencies and programs, however, will have participation restricted only to certain specific multi-state prescription drug aggregate purchasing programs.

Costs

The cost associated with participation in one of the current multi-state prescription drug aggregate purchasing programs is not generally known, however, can be readily assessed. Indiana has conducted an extensive request for proposal process and review as part of the initiation of its own intra-state prescription drug aggregate purchasing program. This process has provided Indiana with the financial and administrative terms for a competitive aggregate program. Specific individual terms such as discounts to AWP, dispensing fees, guaranteed rebates, and administrative expenses can be directly compared to similar values for existing programs. Such a comparison can be used to estimate whether participation in an available multi-state prescription drug aggregate purchasing program is in the best financial interest of Indiana. Such an analysis can be conducted by the state budget agency using an algorithm developed for the analysis of the intra-state prescription drug aggregate purchasing program.[5]

Legal Parameters

An aggregate purchasing program will have certain federal regulatory restrictions limiting the potential participation options. The primary restrictions relate to the pooling of Medicaid populations with non-Medicaid populations.

The primary restrictions to Medicaid programs are promulgated by the federal CMS. Medicaid rebates cannot be extended to state employee programs or other like state accounts such as the prison population.[6] These programs cannot be pooled with Medicaid in supplemental or other rebate negotiations. Medicaid programs can include limited non-Medicaid programs for low income populations if given CMS approval.

CMS will need to approve Indiana's SPA for participation in a multi-state prescription drug aggregate purchasing program prior to joining such a program.

Medicaid programs that capitate both medical and prescription drug benefits cannot pool the prescription drug benefits with fee-for-service Medicaid prescription benefits in an aggregate purchasing program.[6] Prescription drug benefits would need to be "carved out" of the capitation plan in order to be pooled with fee-for-service Medicaid prescription drug benefits.

The CMS restrictions for Medicaid programs are likely the primary reason that other states participate in two different aggregate purchasing programs; one program for Medicaid and one program for all other state programs, accounts, and agencies.

The existing multi-state prescription drug aggregate purchasing programs contain various flexible provisions that are available at the option of the participating state.[2] These provisions include benefit designs, formulary and preferred drug listing, pharmacy network (open versus limited access), and drug utilization programs. Each state has its own contract with the multi-state prescription drug aggregate purchasing program. The state's contract will specify the terms and conditions that will be unique to that state. The financial terms will differ to the extent that each state's terms differ from the most restrictive programs. For example, a formulary and preferred drug list would require benefit design changes to include either economic incentives for selecting the preferred drugs or restrict access to non-preferred drugs. Participation that also includes a common formulary or preferred drug list will result in a greater minimum guaranteed rebate for the state as compared to if the state does not include a common formulary or preferred drug list.[2] Regardless, each state is free to choose the features it wants for its programs.

Each state, however, is relatively unrestricted as to the design of its programs and how such designs may be implemented within a multi-state prescription drug aggregate purchasing program.

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[1] HEA 1265; Section 7.
[2] *Pharmaceutical Bulk Purchasing: Multi-State and Inter-Agency Plans, 2004*; National Conference of State Legislatures. (Updated: September 14, 2004.)
[3] *State Purchasing Pools for Prescription Drugs: What's Happening and How Do They Work?*; NEA Center for Best Practices; August 2004.
[4] *Minnesota Multi-State Contracting Alliance for Pharmacy*; website.
[5] Milliman, Inc. Analysis of Indiana Aggregate Pharmacy Purchasing Program.
[6] *Medicaid Multi-State Pooling Program*. Presentation at the National Academy for State Health Policy's Annual Health Policy Conference (Portland, Oregon, August 4, 2003).
[7] "*Six States Ready for Drug Pool*"; Charleston, West Virginia Daily Mail; August 22, 2001.
[8] *Pharmacy Working Group Request for Proposals*; West Virginia Public Employees Insurance Agency website.
[9] *Milliman Health Cost Guidelines*; Milliman, Inc.; July 1, 2004.
[10] Appendix III.

APPENDIX I

STATE BULK PURCHASING SIGNED LAWS AND EXECUTIVE ORDERS BY STATE, 1999 – 2004

State/law/ web link	Description / excerpts of bill text
AL HB 581 Rep. Beasley (2002)	Authorizes the state to consolidate buying power in pharmaceutical market for price reduction aggregate or negotiate for all state agencies or by "joining a multi-state pooling initiative or both", would authorize the state to negotiate rebates and discounts from pharmaceutical manufacturers. Exempts the Medicaid agency. *(Passed House, 3/19/02, passed Senate 4/11/02; signed by governor as* Act No. 2002-494, *4/26/02.)*|
AK Agency action (2004)	Alaska has filed a Medicaid State Plan Amendment to permit coordinated purchasing with the National Medicaid Buying Pool. The application was approved by CMS as of April 2004.
AR HB 2498 Rep. King (2001)	Authorizes the state to join a multi-state or multi-governmental purchasing consortium for the purpose of purchasing pharmaceuticals and other medical supplies; and for other purposes. Also authorizes expanded use, creation or designation of Federally Qualified Health Centers to access "substantially discounted prescription drug prices." *(Passed Senate and House 4/13/01; signed by governor as Act 1770)*
AZ Executive Order (2003)	Gov. Janet Napolitano signed an executive order setting in motion a new program to allow Medicare-eligible seniors to purchase prescription drugs at lower prices through contracts to be administered by Arizona's Health Care Cost Containment System (AHCCCS.) The order "Explore how prescriptions are now purchased through the State and find the most efficient and cost-effective way to buy prescriptions in bulk through one rather than through several State agencies." *(Executive order signed 1/7/03)*|
CA SB 1315 Sen. Sher (2002)	Requires the Governor to designate a central purchasing agency for purchasing pharmaceuticals. The bill would require the central purchasing agency to execute prescription drug purchasing agreements with certain state entities that purchase pharmaceuticals, unless the entity can purchase the pharmaceuticals for a lower price than through the central purchasing agency. The bill would authorize the central purchasing agency to include the University of California, local governmental entities, and private entities that choose to participate; also includes authorization to contract with a pharmaceutical benefits manager to negotiate prescription drug contracts. The bill would establish reporting requirements for manufacturers of prescription and wholesale distributors of prescription drugs in the state. *(Passed Senate and House 8/02; signed by governor 9/11/02)*
DE HB 300 (2003)	FY '04 budget authorizes the Department of Health and Social Services to contract with a cooperative Multi-State purchasing contract alliance for the procurement of pharmaceutical products, services and allied supplies. *(Passed House and Senate, signed by governor, 6/25/03)*
DC B15-569 Councilmember Catania (2004)	Enacts the Rx Access Act of 2003, requiring the Dept. of Health to run an AccessRx subsidy program; also permits negotiations with other states or jurisdictions for bulk purchasing. Also provides that the Department "shall investigate purchases from outside the U.S. *(Filed 11/4/03; Passed City Council 3/24/04; signed by mayor as Act 15-410) [Also requires ratification by the U.S. Congress]*
GA Executive	Department of Community Health has developed the consolidated drug-purchasing program in Georgia. Combining Medicaid fee-for-service, the public employees and the

State/law/ web link	Description / excerpts of bill text
action (2000)	university teachers, the number of enrollees included in the state drug plan was reported to be 1.2 million as of March 2001. Medicaid is not included in the most recent structure. Express Scripts is the pharmacy benefits manager (PBM) for the program.
ID HCR 26 Rep. Henbest (2001)	Resolution encourages the Governor and the Department of Health and Welfare to "develop a compact with our sister states to facilitate purchases of prescription drugs by the most economic method. Sponsors claimed that "this coalition would ease the rising prices of current prescription drugs on Idaho residents, especially Idaho senior citizens." *News story online* *(Adopted by House, 3/5/01 and Senate, 3/13/01; to Secretary of State, 3/19/01)*
IL SB 3 Sen. Halvorson (2003)	Establishes the Senior Citizens and Disabled Persons Prescription Drug Discount Program Act, requiring the state to "negotiate and enter into rebate agreements with drug manufacturers" to effect prescription drug price discounts, with enrollees receiving the resulting discount. The plan includes multi-agency bulk buying, with details to be finalized by the executive branch. *(Passed House and Senate 5/15/03; signed by governor 6/16/03 as Public Act 93-18)*
IN HB 1265 Rep. Kersey (2004)	Requires the state personnel department to establish a bulk prescription drug purchasing program to negotiate terms related to the purchase of prescription drugs; requires participation by certain entities and allows participation by other certain entities; authorizes the state to enter into multi-state prescription drug bulk purchasing agreements. *(Passed House 2/5/04; passed Senate 2/24/04; signed by governor as Public Law 50, 3/16/04)*
IA H 619 Health Committee (2003) HF 2192 Committee (2002)	HF 619 establishes a multi-agency bulk purchasing council, as well as creates a preferred drug list, increased co-pays and other changes in pharmacy reimbursements for Medicaid. *(Filed 3/18; passed House 4/2/03; passed Senate 4/14/03; signed by governor 5/2/03)* HF 2192 creates the Interstate Prescription Drug Purchasing Cooperative Work Group to determine the feasibility of establishing an interstate prescription drug purchasing cooperative with other Midwestern states. Would include "utilizing regional and national entities such as the Council of State Governments, the National Conference of State Legislatures, and others in establishing contact with the governors and legislative leaders of other Midwestern states"; and other states with existing interstate cooperatives, including the states participating in the tri-state coalition and the northeast legislative association on prescription drug prices. *(HF 2192 amended passed House, 2/12/02; passed Senate 3/18/02; signed by governor, 5/11/02)* Report on Interstate Prescription Drugs - January 2003 [16 pages]
ME S1026; Chapter 786 (2000)	? 2 Purchasing alliances and regional strategies. Authorizes the state to decrease prescription drug prices through purchasing alliances and other regional strategies with other states and private and public entities. *(Passed House and Senate, signed by governor, 5/11/2000. Parts of the law were adjudicated by the U.S. Supreme Court in a May 2003 decision, but section two appears not to be affected - see link below.)*
MA H.4900 (1999)	FY 2000 budget section 271 creates a state "aggregate" or bulk purchasing program, to include Senior Pharmacy Assistance enrollees, Medicare and Medicaid, state workers, uninsured and underinsured people. Up to an estimated 1.6 million people would be involved, with eventual total savings for individuals and government as high as $200 million; also creates a temporary Catastrophic Prescription coverage plan and expands Senior Pharmacy program from $30 million to $72 million. *The text of the 1999 law is on the NCSL web site at* www.ncsl.org/programs/health/drug99ma.htm *(Enacted and signed into law as Ch. 127 by governor 11/16/99; implementation on hold*

State/law/ web link	Description / excerpts of bill text
	by executive agencies and two changes in governor, 2000-2004)
MA H. 4004 Conference Committee (2003)	The FY04 budget, section 19 requires executive agencies to "develop and implement a coordinated prescription drug procurement plan for all pharmacy benefit plans funded or subsidized, in whole or in part, by the commonwealth. The plan shall maximize cost savings, efficiencies, affordability and be designed to improve health outcomes, benefits and coverage in the pharmacy benefit plans. Also mandates that the state "shall contract with a third party nonprofit pharmacy benefits manager to provide pharmacy benefit management services and negotiate pharmaceutical discounts, rebates and other prescription related cost savings with pharmaceutical manufacturers." *(Finally passed by House and Senate, 6/23/03; signed/vetoed by governor 6/30/03)* *[veto recommendation for ?19]*
MI Executive agency (2003)	In February 2003, Michigan's Governor Jennifer Granholm initiated the first multi-state Medicaid purchasing arrangement. The program is run by First Health Services, and is partnered with Vermont and South Carolina as of December 2003. See National Medicaid Pooling Initiative, above.
NV SB 277 Sen. Wiener (2003)	Requires state agencies to purchase prescription drugs, pharmaceutical services, or medical supplies and related services only through Purchasing Division of Department of Administration, unless they can certify to obtaining a lower price from another source. *(Filed 3/13/03; passed Senate and Assembly; signed by governor 5/15/03 as Chapter 97)* | *Update:* Nevada has filed a Medicaid State Plan Amendment to permit coordinated purchasing with the National Medicaid Buying Pool. The application is pending at CMS as of February 2004.
NH Executive agency (2004)	Gov. Craig Benson announced February 17, 2004 that New Hampshire has filed a Medicaid State Plan Amendment to permit coordinated purchasing with the National Medicaid Buying Pool. The application is pending at CMS as of February 2004. The Governor noted that "the state could save up to $15 million a year in Medicaid costs starting next year if it joins the pool. New Hampshire now spends $140 million a year." *(Governor's action, 2/17/04)* "(NH) State Still Mulls Drug Options" - Concord Monitor, February 18, 2004
NM SB 91 Sen. Feldman HB 200 Rep. Picraux (2002)	Establishes the Senior Prescription Drug Program. Eligibility covers persons age sixty-five years or older with no other prescription drug benefit. Directs the Retiree Health Care Authority to administer the program in conjunction with the consolidated purchasing process in the Health Care Purchasing Act. No state funds are appropriated to subsidize drug purchases. [fiscal note] *(Passed House and Senate, 2/02; signed by governor as Chapters 75 and 80, 3/5/02)* *Update:* A February 2004 journal article notes that "New Mexico is creating a massive drug-buying pool to cover all 635,000 state residents who get health care coverage from any public entity. Later, the pool may also purchase medications for the state's 400,000 Medicaid recipients." *Drug Benefit Trends 16(1):11-12, 2004.*
SC S 317 Sen. Elliott (2003)	Creates the Interstate Bulk Prescription Drug Program with neighboring states to provide prescription drugs at a reduced cost to senior and disabled residents who do not have prescription drug coverage. The program is not specifically connected with Medicaid. *(Passed House 5/21/03; passed Senate 6/3/03; signed by governor 6/17/03)* |
TX HB 915 Rep. Gray (2001)	Authorized creation of a system of bulk purchasing of prescription drugs by state agencies, including Dept. of Health, Mental Health, state employees, retirees, teachers, prison system and any other agency that purchases pharmaceuticals. It established the Interagency Council on Pharmaceuticals Bulk Purchasing, and would use existing distribution networks. The Council "shall investigate" options of expanding Medicaid purchasing, and using DSH and FQHC facilities. Final version includes provisions for

State/law/ web link	Description / excerpts of bill text
	manufacturer and wholesaler price reporting and enforcement powers for the Attorney General. [fiscal note online estimates savings of $13 million for first two years] *(Passed House, 4/30/01; passed Senate, signed by governor, 6/15/01)*
VT H.31 Rep. Koch; Sen. Shumlin (2002)	Authorizes participation and financial support for the Northeast Legislative Association on Prescription Drugs; also names the West Virginia multi-state initiative. State departments are directed to aggregate or combine public and private health benefit plans within and outside the states, to achieve better prices for residents. The law also establishes a discount plan via Medicaid waiver, and requires disclosure of pharmaceutical marketing activities. *(Passed by conference committee, 5/28/02; signed by governor 6/13/02)* |
WA SJM 8001 Sen. Franklin (2002)	Resolution, calls for cooperation among Washington, Idaho, Oregon, Alaska and Montana to seek "joint pricing and purchasing agreements for prescription" drugs with savings passed on to consumers. *(Passed Senate, 2/5/02; passed House 3/5/02; signed by President & Speaker)*
WA SB 6088 Sen. Deccio (2003)	Creates a statewide pharmaceutical discount plan for residents with incomes up to 300% of federal poverty, which includes a provision for voluntary negotiated discounts initiated by the Health Care Authority for multiple state agencies. *(Filed 6/5/03 in special session; passed Senate and House; signed by governor 6/26/03)* |
WV S 127 Sen. Tomblin, Gov. Wise (2001)	Allows WV Public Employees Insurance Agency to pursue a multistate buying pool with all state agencies and institutions, as well as "governments of other states and jurisdictions, and "regional or multistate purchasing alliances". Allows "innovative strategies", such as "enacting fair prescription drug pricing policies" and providing discount prices or rebate programs for seniors" and uninsured. The agency may explore "requiring prescription drug manufacturers to disclose to the state expenditures for advertising, marketing and promotion, as well as for provider incentives and research and development efforts." *(Passed House and Senate; signed by governor 5/15/01 as Chapter 97)*
WV HB 4084 Del. Michael (2004)	West Virginia Pharmaceutical Availability and Affordability Act establishes a state-sponsored prescription drug discount card program for residents. It also provides that the state shall "explore the feasibility of using or referencing, the federal supply schedule or Canadian pricing. 4) requires the state to "investigate the feasibility of purchasing prescription drugs from Canada," including feasibility of serving as a wholesale distributor of prescription drugs in the state." *(Passed House 1/22/04; passed Senate 3/13/04, signed by governor 4/7/04)*
WI SB 44 | enrolled (2003) Governor Doyle	2003-4 Budget bill:. Prescription drug cost controls and drug purchasing: authorizes joining a multi-state purchasing group or agreement. Also establishes supplemental rebates for Medicaid, Badger Care and others such as senior pharmacy, if feasible; exempts most mental health drugs from prior authorization [?1393] and makes other pharmaceutical policy change. *(Passed Senate and Assembly; signed/partial veto by governor 7/24/03 as Act 33)*

Source: National Conference of State Legislators; Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans, 2004; September 14, 2004.

APPENDIX II

MULTI-STATE PRESCRIPTION DRUG AGGREGATE PURCHASING PROGRAM QUESTIONNAIRE

Milliman, Inc. has been engaged by the Budget Office for Indiana to review the feasibility of Indiana participating in a multi-state prescription drug aggregate purchasing program for its employees, state universities/colleges, school systems, and local units of government. Milliman has prepared a brief questionnaire as part of this engagement. We are asking your participation to help Indiana review the feasibility of a multi-state prescription drug aggregate purchasing program. We will compile the results of the responses and return the results to you as a gesture of thanks for participating.

The questionnaire is shown below. We ask that you reply with your information on or before October 8, 2004. Please email your response to art.wilmes@milliman.com

1. Does your state currently participate in a group purchasing pool for the purpose of purchasing prescription drugs?

— Medicaid population:	Yes	No
— CHIP Programs:	Yes	No
— State employees:	Yes	No
— State Colleges/Universities:	Yes	No
— Schools and local units of government:	Yes	No
— Prisons/State Hospitals:	Yes	No
— Senior drug programs:	Yes	No
— Uninsured/Underinsured programs:	Yes	No

2. What is the name of your purchasing pool:

3. Is your purchasing pool part of a multi - state program? Yes No N/A

4. What other states participate in the purchasing pool?

5. Is there interest in participating in a multi-state program? Yes No N/A

6. Please respond to the following questions if you currently participate in a group purchasing pool:

— Is the pool managed by a Pharmacy Benefit Manager	Yes	No
— Does your state include multiple accounts (*e.g.,* different state agencies, police, etc.)	Yes	No
— Do you have separate accounting (*e.g.,* rebate payments) and reporting by account:	Yes	No
— Do you audit the contract provisions (*e.g.,* rebates, AWP discounts, etc)	Yes	No

6. Please respond to the following questions if you currently participate in a group purchasing pool (*continued*):

— Does the purchasing pool require a preferred drug list (PDL)	Yes	No
— Did the purchasing pool result in changes to plan designs (*e.g*,, copay tier changes)	Yes	No
— Does your purchasing pool include mandatory generic use	Yes	No
— Does your purchasing pool include other drug utilization programs	Yes	No
— Are you satisfied with the service provided by the purchasing program	Yes	No
— Are the financial results/savings consistent with initial expectations	Yes	No
— What percent savings were you expecting	0% - 2.5% 5% - 7.5% > 10%	2.5% - 5% 7.5% - 10%
— What percent savings are you receiving	0% - 2.5% 5% - 7.5% > 10%	2.5% - 5% 7.5% - 10%
— Did member copayments increase when the program was initiated?	Yes	No

7. What challenges or transition issues did you experience when you implemented the pool:

_____

_____

8. Any additional comments

_____

_____

Thank You.

APPENDIX III

MULTI-STATE PRESCRIPTION DRUG AGGREGATE PURCHASING PROGRAM QUESTIONNAIRE RESPONSES

State Survey Responses

States Responding		Minnesota	West Virginia	Wisconsin
1	Does your state currently participate in a group purchasing pool for the purpose of purchasing prescription drugs?			
	Medicaid Population	YES	NO	NO
	CHiP Programs	NO	YES	NO
	State Employees	NO	YES	NO
	State Colleges/Universities	YES	YES	NO
	Schools and Local units of Government	YES	YES	NO
	Prisons/State Hospitals	YES	NO	YES
	Senior drug programs	NO	NO	NO
	Uninsured/Underinsured programs	NO	NO	NO
2	What is the name of your purchasing pool:	National Medicaid Pooling Initiative (NMPI) Minnesota Multi-State Contracting Alliance for Pharmacy (MMCAP)	RXIS	MMCAP
3	Is your purchasing pool part of a multi-state program?	YES	YES	YES
4	What other state participates in the purchasing pool?	NMPI: MI, VT, AK, NV, HI, NH MMCAP: AL, AK, AZ, AR, CO, DE, FL, GA, HI, ID, IL (City of Chicago), IN, IA, KS, KY, LA, ME, MD, MI, MN, MS, MO, MT, NE, NV, NH, NM, NY, NC, ND, OK, OR, PA, RI, SC, SD, TN, UT, VT, VA, WA, WI, WY	NM, MO, OH, DE	At least 43 other states participate
5	Is there interest in participating in a multi-state program?	YES	YES	YES
6	Please respond to the following questions if you currently participate in a group purchasing pool:			
	Is the pool managed by a Pharmacy Benefit Manager?	NO; NMPI administered by First Health Services Corporation (PBM)	YES	NO
	Does your state include multiple accounts (e.g., different state agencies, police, etc.)	NMPI -- NO MMCAP -- YES	YES	YES
	Do you have separate accounting (e.g., rebate payments) and reporting by account?	NMPI -- NO MMCAP -- Collects admin fees, but NOT rebates	NO	
	Do you audit the contract provisions (e.g., rebates, AWP discounts, etc.)?	YES	YES	
	Does the purchasing pool require a preferred drug list (PDL)?	NMPI -- YES MMCAP -- Uses market share agreements/ price incentives to concentrate purchasing volume	NO	NO
	Did the purchasing pool result in changes to plan designs (e.g., copay tier changes)?	NO	NO	NO
	Does your purchasing pool include mandatory generic use?	NMPI -- NO; State's Medical Assistance Program requires use of generics MMCAP -- Leaves decisions to state and facility authorities, not made at cooperative level	YES	NO
	Does your purchasing pool include other drug utilization programs?	NO, but control drug utilization in other ways	YES	

MULTI-STATE PRESCRIPTION DRUG AGGREGATE PURCHASING PROGRAM QUESTIONNAIRE RESPONSES

State Survey Responses

States Responding		Minnesota	West Virginia	Wisconsin
6	Please respond to the following questions if you currently participate in a group purchasing pool *(continued)*:			
	Are you satisfied with the service provided by the purchasing program?	YES	YES	YES
	Are the financial results/savings consistent with initial expectations?	YES	YES	YES
	What percent savings were you expecting?	Unknown for NMPI - new implementation		
	0% - 2.5%			
	2.5% - 5.0%			
	5.0% - 7.5%	MMCAP	XX	
	7.5% - 10.0%			
	> 10.0%			
	What percent savings are you receiving?	NMPI Unknown; too early		
	0% - 2.5%			
	2.5% - 5.0%			
	5.0% - 7.5%		XX	
	7.5% - 10.0%			
	> 10.0%	MMCAP - 11.5% OFF WAC		
	Did member copayments increase when the program was instituted?		NO	N/A
7	What challenges or transition issues did you experience when you implemented the pool?	NMPI implementation appears to be going smoothly. MMCAP operating since 1989 - States joining using have minimal problems with transition, based upon feedback received.	Since all participants are public payers, each State must contract with PBM individually. Issues encountered were what you would expect to see with any PM transition. WV transition went fairly well.	
8	Add additional comments.		The CHiP program participates only in the fact that they use the TPA and PBM contracts of PEIA. Two RXIS states are just beginning the audit of the PBM. RXIS does not require a PDL, plan design changes, or mandatory generic use. However, per the benefit design, PEIA uses all 3 methods of management. RXIS pricing is based on sliding scale depending on number of lives in pool. Benefit design also determines guaranteed pricing, for example, depending on copay structure, copay differential, PDL, etc.	Check with MMCAP administrators at mn.multistate@state.mn.us for more details about the multi-state coop program for government facilities. Wisconsin Dept. of Employee Trust Fund contracts with Navitus for PBM services for state employees. Plan uses tiered copayment system linked to PDL and supplemental rebates. Currently does not involve purchasing pooling with other groups.